PATIENT SAFETY

FEEDBACK

Patient Safety Reporting System
P.O. Box 4
Moffett Field, CA
94035-0004

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FEEDBACK shares excerpts of reports sent by VA personnel to PSRS. Actual quotes appear in *italics*. Created by an agreement between NASA and the VA in May 2000, PSRS is a voluntary, confidential, and non-punitive reporting system. PSRS encourages VA personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

Emergency Situations Prompt PSRS Reports

Watch That Spark

An anesthetist alerted a surgeon to a dangerous situation in time to prevent a possible fire in the operating room.

- *A patient was undergoing a tracheostomy under general anesthesia. He was intubated receiving at least 50% oxygen through the endotracheal tube. The surgeon had made the initial incision and had entered the trachea causing anesthetic gases and oxygen to flow out of the tracheostomy incision. About this time, the surgeon grabbed the electrical cautery to cauterize a bleeding vessel at the wound site.*

At this point the reporter intervened:

- *I immediately said, "There is a very high concentration of oxygen coming out of the wound." As a result, the surgeon did not cauterize the bleeding site, thus possibly averting an explosion* [fire] *from the high concentration of oxygen and electrical current.*

The reporter was concerned:

- *There is not a departmental policy/procedure that addresses this issue.*

Recent case reports support this concern:

1. *Ann Otol Rhinol Laryngol Jan 1991*
2. *Ann Otolaryngol Head Neck Surg Jan 1992*
3. *South Med Journal Mar 1998*
4. *Ann R Coll Surg Engl Nov 2001*
5. *Ear Nose Throat Journal Feb 2002*
6. *Acta Anesthesiology Sin Dec 2002*

Ensuring Safer Exiting

Planning ahead to more easily evacuate their healthcare facilities in the event of an emergency prompted two PSRS reporters to offer suggestions. In the first case, a veteran's support group continued to meet after a fire drill began, rather than leaving the building. Once alerted to the need to evacuate, the elderly veterans faced some challenges:

- [The veterans] *have many serious debilitating disabilities. Our meeting is on 2nd floor…* [where] *the elevators automatically lock, so the group helped each other* [down the stairs], *some with walkers or canes, and one veteran was carried down the stairway in his wheelchair.*

The group eventually got outside, but they reflected on their performance:

- *… In subsequent weeks* [the veterans] *pointed out how hard and slowly it had gone. So we traded and moved to a first floor meeting room now. I had never considered how debilitated they had gotten and wonder if the rest of the VA system needs to be thinking about that. …None of our group was hurt, but in an intense fire with much smoke, I wonder how well would they have done?*

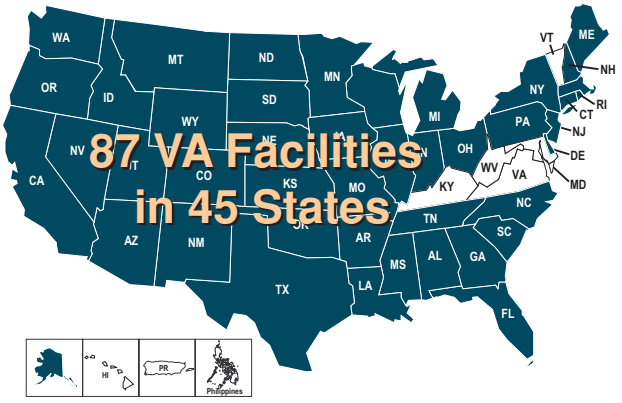
The second reporter noted:

- [We need] *to improve the safety of our patients in the event of an emergency such as fire, explosion, tornado, attack by terrorists, chemical or biological warfare…With all the clutter in the hallways of carts, computer tables, serving tables or carts, wheelchairs, medical monitors, and scales, it would be a tremendous task to get the patients out with wheelchairs, and an impossibility removing the patients attached to their beds and monitors, with no time to put them in wheelchairs.*

The reporter envisions matching specific employees to specific pieces of equipment:

- *Have an employee assigned to each item clogging the halls. When the task with this item is completed, the item would be placed into a room or storage area out of the halls. If an emergency arises, the item would be immediately removed from the halls by the employee assigned to it.*

PSRS Outreach Status



The PSRS medical analyst team has conducted over 356 educational briefings to over 12,000 VA employees at VA facilities nationwide.

Smoke Gets in Our Eyes

Two reporters described some hazards they observed with patients smoking. The first reporter described a potentially fatal accident:

- *The patient in a wheelchair went to smoking room. Nursing staff heard screaming from room, found the patient lying on the floor with flames on chest.* [An employee] *used the pillow from the wheelchair to put out the fire. Another RN put out a lighted cigarette and then called emergency ambulance… The patient was transferred to a burn unit at affiliated hospital.*

This event prompted changes in their "safe smoking" environment:

- *Water extinguisher (to decrease respiratory irritation when deployed)*
- *Fire blanket outside of room*
- *Metal furniture instead of naugahyde*
- *Bigger windows in door to room to observe patient*
- *Removal of flammable items in area (plastic bags)*
- *Enough good, big ashtrays*

They changed some procedures as well:

- *Assessment tool used will include inquiry into safe smoking determination and evaluation of prior smoking accidents/ close calls, as well as enlistment of family or visitors for assisting/observing smokers in the smoking room.*

The second reporter focused on some different issues found in a psychiatric setting:

- *Patients are allowed off unit to smoke after they have been here 72 hours, and are deemed 'no harm to self or others.' We have scheduled smoke/off ward times… We have had several small fires in the past — one patient was burned... it is impossible to police our clients when they are off ward. Not enough staff to escort them.*

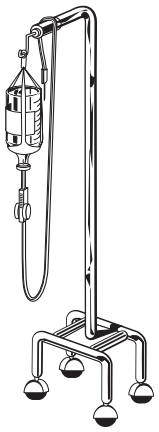
The reporter predicted another undesirable consequence:

- *Patients come up en mass to get cigarettes and lighters, which are kept in nurses' station… the same area meds are administered. There is almost always lots of clamoring and demands for staff to hurry and 'sign them out' for a smoke. There is a potential for making med error, due to the congestion.*

For Want of an IV Bag Label

Not knowing that an IV bag contained an additive is a problem, according to a PSRS reporter:

- [I] *took a 500 cc normal saline bag from the unit refrigerator and almost hung it for bolusing a hypotensive fresh postop patient* [and] *found a sticker label that had fallen off the bag that said heparin was added.*



The reporter asked for more secure labeling:

- *IV bags with heparin in D5W come marked (red markings on the IV bag) from the pharmacy. If a heparin solution needs to be in normal saline, a white peel-on label is placed on the IV bag. If the label comes off there is no way to identify that there is heparin in the bag… Any bag with heparin should have markings on it that can not come off.*

PSRS Report Forms are available at VA Facilities and online at: http://psrs.arc.nasa.gov

Future issues of *FEEDBACK* can be sent directly to you:

VA employees can subscribe at no cost by going online to http://psrs.arc.nasa.gov and clicking "Contact Us."

Or mail your request to:
PSRS, P.O. Box 4
Moffett Field, CA 94035-0004

Past issues of *FEEDBACK* are available on the VA Intranet at: http://vaww.ncps.med.va.gov/PSRS.html

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Space Administration
MS IHS 262-7
Ames Research Center
Moffett Field, California 94035-1000

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